EXHIBIT 9

STATE OF TENNESSEE
HEALTH SERVICES AND DEVELOPMENT AGENCY

EXCERPT OF PROCEEDINGS

August 24, 2016

EAST TENNESSEE HEALTHCARE HOLDINGS, INC.

CN1605-021

LEGISLATIVE PLAZA
Room 12

Sixth Avenue North & Union Street

Nashville, Tennessee

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The East Tennessee Healthcare Holdings, Inc., CN1605-021 project was heard on Wednesday, August, 24, 2016, beginning at 1:07 p.m. at the Legislative Plaza, Sixth Avenue North & Union Street, Room 12, Nashville, Tennessee, before a quorum of the following board members:

BOB DOOLITTLE, CHAIRMAN
THOM MILLS, VICE-CHAIRMAN
LISA JORDAN
COREY RIDGWAY
KEITH GAITHER
TODD TAYLOR
PAUL KORTH
MARTIN FLEMING, M.D.
JOE GRANDY

AGENCY STAFF PRESENT:

Melanie Hill, Executive Director

Mark Farber, Deputy Director

Mark Ausbrooks, Administrative Services Assistant III

Jim Christoffersen, General Counsel

Rhonda Finchum, Administrative Officer

Alecia Craighead, Statistical Analyst

Phillip Earhart, HSD Examiner

Court Reporter: April N. Daniel, LCR
LCR No. 141
Expires 6/30/2018

P R O C E E D I N G S

EAST TENNESSEE HEALTHCARE HOLDINGS, INC.
CN1605-021
(Motion to Approve)

MR. FARBER: East Tennessee Healthcare Holdings, Incorporated, Johnson City, Washington County, CN1605-021. This application is for the establishment of a nine residential substitution based treatment center for opiate addiction. The estimated project cost is $1,747,777. Mr. Ridgway will be recusing on this application.

With regards to opposition to this application, there are a number of residents of Gray, Tennessee, who are opposed to this application as is evident on the public hearing minutes that you received; and with the attachment to your agenda includes the list of opposition and, of course, the letters that you have received. There are some members of the opposition here today that plan to speak, Brian Davenport, the County Commissioner and a resident of Gray, Pam Davis, resident of Gray, Sharon Oliver, a resident of Gray, Debbie Wise, resident of Gray, Mark Larky, who's a County Commissioner and resident of Gray, and Danny Sells, also a resident of Gray.

MR. DOOLITTLE: Thank you, Mr. Farber. Mr. Christoffersen.

MR. CHRISTOFFERSEN: Thank you, Mr. Chairman. I'd like to make a few comments to hopefully offer some guidance to our new members and/or members who are new to the Agency since we've last had an application for one of these types of facilities.

In the past, I've offered some guidance that I'm actually going to try and read almost word for word of a prior transcript of one of these Agency proceedings; and the reason why I do this is because a lot of issues can come up or can be brought up by people in support or opposition of these applications, and I want to try and put the Agency's focus on what its statutory charge is and what it needs to do in these cases. And that isn't to suggest whether you approve or deny it but rather the lens through which you should view the application when making that determination.

This is not the first methadone application for a Certificate of Need in the state of Tennessee. The Agency and its predecessors have heard applications before, and there are currently, I believe, 12 that are licensed in this state. The state of Tennessee is long recognized as is the Health Services and Development Agency and its predecessor. Lots of good people suffer from addiction to opiates.

This is not about whether or not the problem exists or about whether having these folks in the community as desirable. Any comments today that are geared toward that are really going to miss the mark as to what the decision is to be based on by law. That isn't to dismiss any and all opposition to the project but just and try to steer you what is relevant to the law you're charged with enforcing. This is about what treatment is best for these folks within the framework of Tennessee law.

The decision needs to be guided by state law as provided in 68-11-1609 of the Tennessee code or what we used to call the three criteria, which is now the four criteria, of need, economic feasibility, contribution to the orderly development healthcare, and now the new criterion, whether the proposed project meets appropriate quality standards for the service to be provided. The statute also calls for the Agency to be guided by the State Health Plan when making these decisions which lays out additional criteria which is what's either referred to as the Guidelines For Growth or sometimes just the Guidelines.

The Davidson County Chancery Court has held that an Agency follows the guidelines laid out in the analysis by the reviewing Agency that can provide a

basis for a decision. It doesn't necessarily mean that it will, though, in all circumstances be the only decision you can make or necessarily be the decision. It's just there will be a lower level of scrutiny on any level appeals if that's done. But if the Agency does make a decision outside the framework of that, good reason needs to be provided for doing so. And as those of you who have been on the Agency have experienced, there are times when there's good reason to make a decision outside of the guidelines of the State Health Plan. Just remember that if you have a decision geared toward that, your motion should contain good reason for doing so.

The Department of Mental Health and Substance Abuse Services has staff here that is available to answer any questions you may have about their role, the role they've played in preparing the report, and any questions you may have about the services that are provided. There may be comments made in support or opposition to the application or you may have come up with questions of your own from reading the application, and they're here to try to answer any questions that you may have.

Hopefully statements and inquiry today will be limited to state law and the Agency's rules and

you won't get pulled in other directions which sometimes ends up happening. I'll be prepared to perhaps step in if there's any possibility of running a foul of any federal laws as well.

Under the Americans with Disabilities Act, which is very comprehensive in what it requires of people, technically patients who are addicted to opiates but are seeking treatment or in treatment as opposed to those who are not are considered disabled under that law. And since they are, the federal government, not only does it regulate methadone so strongly, but under the ADA, it also gets involved as well. So if anything comes up that bumps up against that, I'll try to interrupt and steer folks into that right direction.

If you have any questions, just please let me know.

MR. DOOLITTLE: Thank you, Mr. Christoffersen.

Mr. Elrod, by prior agreement with the staff, the applicant will have 30 minutes in the aggregate to make its presentation, and we will give equal time in the aggregate to the opposition.

MR. ELROD: Thank you, Mr. Chairman and members of the Agency. And just by way of

clarification, we will save some time for rebuttal to be a part of our 30 minutes.

MR. DOOLITTLE: That'll be fine.

MR. ELROD: I'm Dan Elrod. I'm here along with my colleague, Travis Swearingen, on behalf of this applicant and this project.

The applicant is a joint venture owned equally by Mountain States Health Alliance and East Tennessee State University Research Foundation. Mountain States Health Alliance is a nonprofit healthcare system with facilities and services throughout northeast Tennessee and southwest Virginia. The East Tennessee State University Research Foundation, as the name indicates, is affiliated with East Tennessee State University.

This project is not like other substitution-based treatment centers previously considered by the Agency. The facility proposed by this application will be just one aspect of a comprehensive recovery-based treatment program. The goal of this program is to provide opiate-addicted patients a pathway to recovery. For some patients, methadone is an essential component of that recovery process.

The facility will make available a full

spectrum of therapeutic and recovery-based services through a contract with Frontier Health, the largest provider of outpatient mental health and substance abuse services in the region. As will be explained in more detail, the project involves a unique collaboration of three major nonprofit organizations that have demonstrated their commitment to address opiate addiction epidemic that is so prevalent and so devastating in the region and to do so with the utmost quality and care of patients in mind.

With regard to need of this project, there are two compelling points to make initially: One is the prevalence of the opiate epidemic, and you've already heard something about that this morning in an earlier application. Tennessee has the second highest opiate prescription rate in the United States, and this problem is particularly acute in northeast Tennessee, Sullivan County, which is where Kingsport is, has the highest hospital discharge per capita in Tennessee for drug abuse and overdose. Washington County has the third highest.

As the Johnson City Press noted in a recent editorial, "This region is ground zero for the opiate problem in Tennessee." So it's obvious that ETSU has established its center for prescription drug

abuse prevention and treatment that you'll hear more about in a few minutes.

The second point supporting need for this project is the great difficulty that patients currently experience -- excuse me just a minute. I need to get my pointer, or my clicker. Thank you. I didn't come fully armed.

The second point about the need for the project is the difficulty the patients are facing now getting access to methadone treatment services. Methadone assisted therapy, as Mr. Christoffersen has indicated, is a well-established effective model for opiate addiction. There are 12 facilities licensed in Tennessee in nine different cities, but there are none in Tennessee east of Knoxville.

And this is the service area for the facility, and the dot or the star is the proposed location for the facility. And in the dark blue counties, which is the primary service area, there are no facilities that we propose like that in the area. There are a significant number of physicians in this area who are authorized to prescribe people Buprenorphine, which is another substitution-based medication commonly known as Suboxone, but there are some patients who simply don't respond well to that.

So with those patients, they are at a great disadvantage and have great burden in accessing services.

This is another map. This map actually shows the locations of the methadone clinics available in the area, and you can see they are a significant distance. Depending on where you live in the dark blue counties, the closest facilities are either in Knoxville, Weaverville, North Carolina, Boone, North Carolina, or Cedar Bluff, Virginia. For most patients, the one-way drive time is 45 to 75 minutes to access this service.

This project will meet the need for better access to the methadone option and it do so in the context of a comprehensive treatment program with a full array of treatment services. The project is optimally located near the confluence of I-81 and I-26, so it's accessible to patients throughout this region. We acknowledge there's some resistance and concerns have been raised by the location, and we'll address that as the presentation and rebuttal goes on this afternoon.

With regard to financial feasibility, the project will be funded by Mountain States Health Alliance cash reserves, and the resources of Mountain

States Health Alliance stand behind this project. The project will be profitable by the second year, as indicated in the application.

The project's contribution to the orderly development of healthcare as well as the demonstration in terms of commitment to quality standards, all of that's reflected in the many letters of support that the Agency has received from healthcare providers, addiction services advocates, other providers who are currently seeing addictive patients in the area, law enforcement, and other members of the community, and perhaps most significantly is the report from the Mental Health and Substance Abuse Services, which establishes that this project frankly meets all the criteria.

In terms of in order to understand better the collaboration that's involved here as well as how this project will, in fact, adhere to applicable quality standards, now I'm going to ask representatives from the three collaborating organizations to come forward and make a few comments. When they're done, Mr. Chairman, that will complete our principle application. There is at least one other person here not associated with us who would like to speak. But when Ms. White completes her comments, that will end

our main presentation. And we have a number of people here, obviously, to answer any questions submitted.

MR. DOOLITTLE: Okay. And assuming you don't use the 30 minutes, you want to preserve the rest for rebuttal?

MR. ELROD: Yes, sir.

MR. DOOLITTLE: Okay. Fine. And the additional person who's not part of the application who wishes to speak, when they are done, you will speak. Thank you.

MR. PACK: Good afternoon. My name is Robert Pack. I'm a professor and associate dean for Academic Affairs at College of Public Health and East Tennessee State University, and I'm the Director of the Center For Prescription Drug Abuse Prevention and Treatment. I'm glad to be here today to speak with you.

In our college, we host an active working group on prescription drug abuse and misuse. It has about 150 members that are in the community and at the university. We have the common goal of reducing the burden of addiction in our region. And this year, the working group proposed an established research center for prescription drug abuse prevention and treatment that actually includes a number of research projects

that are ongoing right now focused on prescribing, dispensing, patient communication with prescribers and dispensers, neonatal absent syndrome; we have projects focused on the Naloxone distribution and workforce health promotion, which we do in collaboration with Washington County.

There are a number of different studies ongoing from that working group, but what we really lacked was, we lacked a treatment component to the center, and so we began to imagine how we might partner with clinical folks around; reached out to Mountain States Health Alliance, and they agreed to be our clinical care provider for, really, the fourth quadrant, if you will, for what we're trying to get moving with the center. So our center has a lot of folks that are already engaged with us. We've been going since about 2012, but approved this year. The community engagement is high, but this new clinical treatment side is what we're here to discuss today.

I want to point out that for each of our folks that are associated with the center that have some proportion of time devoted to it, each one of those people will be devoted to an evidence-based intervention that will be implemented at different points along the continuum of addiction. So in this

example here, it's really the continuum of addiction in the middle. But there are very strong excellent evidence-based studies, in fact in some cases, Cochrane reviews, that point to the evidence for each one of those blue boxes.

So, for example, implementation of primary prevention programs, the use of medication-assistant treatment, which has a good evidence-base overdose reversal within the lock zone. All of these different things have to be used together to push back against the problem of -- against the epidemic of prescription drug abuse or opiate addiction. Any one of them alone is insufficient.

So we're here to talk about the MAT, or the methadone based therapy today, but it's only one of the things that we're monitoring, evaluating, and trying to implement in a systematic way in our region through the center, and that's why we became affiliated or wanted to become affiliated with Mountain States and Frontier on this. So that's just an orientation toward our paradigm, if you will.

This is, I think, important. It is an absolutely essential-needed component for our region, and is one that if we don't do it, there will be a for-profit provider that comes in right behind us.

MR. JESSEE: Good afternoon. My name is Randy Jessee, and I'm the Senior Vice President for Frontier Health Specialty Services division. A little bit about my background: I have 36 years of alcohol and drug treatment program development and provision, management of services. I am a resident of Gray, Tennessee, myself.

Frontier Health has 56 years, basically, of experience in substance abuse addiction treatment; and as a nonprofit corporation, a continuum of care, that includes both outpatient and residential treatment services, detoxification services, case management, and other ancillary services that go with those. The service area has eight counties of Region One of northeast Tennessee and three counties in PD One, Planning District One, in southwest Virginia.

Frontier Health in the last fiscal year had 50,000 individual lives impacted in dealing with clients, patients, and coming through our services. There are 62 total facility sites; 42 of those are major sites with adult and CNY children and youth services connected with those, and of those 42, there are 20 primary outpatient service areas and also includes residential detoxification and rehabilitation facilities for men and for women.

Frontier Health is accredited by the Commission on Accreditation of Rehabilitation Facilities -- that is CARF -- and they're certified as enhanced co-occurring disorder services from Tennessee Department of Mental Health and Substance Abuse Services in the state of Tennessee.

In 2004, Frontier Health initiated medication-assisted treatment in southwest Virginia with a program using Buprenorphine products -- primarily Suboxone -- and that commences into today. There are presently, I think, 45 particular patients at those clinics in Jonesville and in Big Stone Gap.

In Tennessee, Suboxone services would begin in November of 2016 based upon grant and support funds from the Tennessee Department of Mental Health and Substance Abuse Services.

Frontier Health is staffed by a number of professionals. The primary ones I will just list to you now. There are nine psychiatrists, there are four Ph.D. psychologists, there are 15 advanced practice nurses, there are 129 master's degree licensed and license eligible therapists, there are 37 nurses of RN and LPN capacity, and there are 165 case managers serving individuals in our service area.

One of the key things designed in this

particular approach is the use of wrap-around services, which are structured services and services of need of any patient that would come through the facilities. And those things include medication assistance, job training and placement, housing assistance, transportation, child care, and other kinds of needed services for individuals as they go through treatment or come out of treatment at discharge. There's seamless transfer of these individuals as they involve in-services and coming out of services. Their needs are continuously assessed by treatment teams that they're involved with while they're in the treatment process at different facilities, and that's documented in specific treatment plans, individualized treatment plans as mandated by state requirements.

Case managers and therapists then make sure that the actions connected with that treatment plan are followed up and any needs that are provided as needing to be enhanced within their episode of treatment, that they're actually connected and then met and confirmed that they participate in those processes. Referrals to those services take place in the local communities in those centers, as you can see, that are around in the major towns and cities in the region.

And some of those also are connected

right inside the facilities with case management services and with the therapist there while they're in treatment and setting folks up for a timely and appropriate discharge back into their community to resume. Most of these individuals do require a more structured living practice and experience and support as they continue on in life of recovery.

And as such, some of the examples of some of those local services are state provided as well as locally provided by smaller agencies or other agencies in the community. Some of those things that come from the state directly are the safety-net services that are provided through the Department of Mental Health and Substance Abuse Services, TTS, which is an after-hospitalization type referral service for needs of individuals and a homeless service also as well for those, and that's involved for both women and men.

And, I guess, my last comment is that in the process of delivering medication-assisted treatment, there are usually two components to that; and those two components consist of, one, the medication administration, whatever that medication is, and then recovery component. Some of that recovery component in this particular facility will occur at that site, and other more extensive services in terms

of treatment will occur off site in community-based facilities. And recovery is a combination of stabilization through the medication and also through the recovery treatment process, which is conducted both in individual group sessions also family sessions and other significant services such as case management.

And as a whole, over time, Frontier Health has had, I think, a significant impact in terms of folks going through treatment, and approximately 66 percent of those individuals that are involved in treatment through our facility on an annual basis complete that treatment and go on back into the community with support services to try to put their lives back together.

The MHCA, Mental Health Corporation of America, client reports also state that we had high ratings through treatment of effectiveness and also therapist effectiveness scores as well.

And that is all I have. Thank you for your time.

MR. DOOLITTLE: Thank you, Dr. Jessee.

MS. WHITE: Good afternoon. I'm Lindy White, Vice President within Mountain States Health Alliance. I currently serve as Chief Executive Officer of two of our community hospitals in Washington

County, Tennessee; one of those being Woodridge Hospital, which is an 84-bed inpatient behavioral health hospital. I've been a leader within Mountain States for 15 years, and I am a current resident of Gray, Tennessee.

Of the 84 beds that I mentioned in our hospital, the largest unit within that hospital is a 26-bed unit that serves patients that are hospitalized for addiction and for co-occurring diagnoses. That includes over 1,700 hospitalized admissions per year. And as part of our commitment to the behavioral health service line, we at Mountain States Health Alliance also offer two programs to intensive outpatient therapy one of those that's dedicated to our patients suffering from addiction.

Already covered extremely well in the opening comments was the extent of the opiate addiction in our region, and the problem is complex. And that's why we are so excited as we came together with ETSU to put together a more comprehensive approach. Mountain States, as a healthcare system, we've been asked -- 13 hospitals and 29 counties.

We've been asked several times to consider a traditional methadone clinic and operation of one. We've deferred because we felt that model

traditional clinic was not at the good fit that we needed in our region. We did not feel that the depth of service was not there to be comprehensive enough to really start to tackle this complex issue. Therefore, the strength of this proposal in front of you today lies with the collaboration of our project that we are proposing. ETSU, Mountain States Health Alliance, and our friends and partners are already in services around addiction with Frontier Health, as Mr. Jessee just mentioned.

Our model is really a three-legged stool: A regional clinical footprint already established well in Tennessee and Virginia, an opportunity to obtain research status so that we can continue to build best practices to fight this terrible epidemic in our region, and the connectivity of already well-established healthcare services across the continuum is the strength of this project. Disease management, housing instability, employment needs, all of those, the three legs of this stool can meet.

In addition to our well-established history in providing treatment for addiction, including therapy and counseling services, we have made multiple site visits as a commitment to this program. This is a new tool in our tool kit. We understand that. We have

spent months studying this and different site visits to ensure that we can bring this comprehensive approach to our community safely and with extreme quality of care for our patients.

It is the broad continuum of care with the project that we proposed. As part of that continuum, we also know that our communities and our residents are also the key stakeholders in this project. We have engaged the community on several occasions as far back as May in smaller work groups with concerned citizens and local legislatures, and we've also had several opportunities in much larger group forums to hear their concerns, and we have heard them and we have considered them.

Finding an ideal site for this project has no doubt been the challenge. Collectively working with the mayor and the concerned citizens of Washington County, we've looked at 40 alternative sites seriously, and together and collectively, the mayor brought forth one of those, which we seriously considered. And that particular alternative was in a much more heavily congested area and was going to cost far more to develop this project, including the construction of a new building.

The unique model that we bring together

as for profits today, obviously we're concerned about the financial feasibility. But as part of this project, any profits and proceeds that come from this collective project together is going to go back on the front end part of the center to continue to fight and put together best practices for prevention and education. That's another reason why we're concerned about the financial cost associated with the other site.

With that, we feel like this recovery-based addition treatment facility incorporates medication assistance. Yes, it's a new tool methadone and a ray of treatment services. But we do feel like this is ultimately going to be a comprehensive approach to really start to tackle this epidemic in our region, and I ask you to consider a favorable response to this unique comprehensive approach for the citizens of our region to create a safer place for our families. Thank you.

MR. DOOLITTLE: Thank you, Ms. White.

MS. COFFEE: Good afternoon. Thank you for letting me speak. My name is Rhonda Coffee. I'm here to today as a parent --

MR. DOOLITTLE: Ms. Coffee, let me just make it clear; you are speaking independently of the

applicant?

MS. COFFEE: Absolutely.

MR. DOOLITTLE: Okay. So just for Mr. Elrod's entertainment, you have six additional minutes on your rebuttal after opposition.

MR. ELROD: Okay. Thank you. Your time is not included. Please go ahead.

MS. COFFEE: Okay. Thank you. I'm here as a parent. This is a picture of my son when he was three years old. I didn't know when I took this picture that he would grow up to be an addict. None of us know that. We can't know that. But David was more than his addiction. He earned a degree. He was happy. He was productive, but he was an addict. He fought hard to not be an addict. One year ago, I lost him. He succumbed, and he couldn't fight anymore, so now I fight.

We considered this option, but it was far away. It was inconvenient. He thought other methods were better. We had a lot of reasons we didn't consider this method. Now I read a lot about different things that are good, and I know now that someone who was chronic in the relapses, as he was, that this was a good option for him. And I know now that no one method is the only method that every addict needs all the

available options at their fingertips. We need to make their lives easier, not harder. We don't need to make people drive 75 minutes one way to get treatment. We need to give them the options at their fingertips so they can get well, so they can live productive full lives. We need to help them, not push them down. We need to ease the stigma, and we need to help, not hurt. This option works for some. It won't work for everyone, but it will work for some. It does work for some. I am in contact with many that it works for. I have formed a support group, and some of those people are in my support group. It started out just being for parents, but it's blossomed into a lot more.

So I work as an advocate now, and it's my hope that I can speak for all of those that are afraid to speak. And so I'm speaking for those that didn't have a voice to come here today that didn't have the means, the method, who just didn't feel brave enough to write a letter or speak out, but they need this. They are living in total hell every day and they get up and they make that drive and then they come home and then they go to work and they raise their families and they need this.

So let's help them. Let's make their lives easier because addiction is a disease. It's not

a punishment. It's a disease, and we can help be part of the cure in some form. So let's remember we can't guarantee when we snap these pictures of our children that they won't be an addict. I never dreamed that for my child. He didn't dream it for his self. And I certainly didn't dream that I would have to bury him 30 years later. So I ask you to take it to heart.

MR. DOOLITTLE: Thank you, Ms. Coffee, and we'd like to express our sympathy for your loss. The opposition will now present. You have been promised an aggregate of 30 minutes and you can, depending on the length of your comments, it's probably easier if two or three of you line up over there and we'll just work through it.

MR. CHRISTOFFERSEN: If I can be so bold to interrupt, since y'all aren't familiar with the process, I just want to remind you that each one of you, state your name as you begin to speak in the microphone for the record.

MR. DAVENPORT: My name is Brian Davenport. I'm a Washington County Commissioner and a resident of Gray. I'm here today to speak for the area that I represent and also myself since this facility is going to be just a couple of miles from my home. Again, and you will hear many times and you'll

see on the map, that this location is on the very far edge, the outskirts of Johnson City, as far out as they can put it. A matter of fact, the residents are county residents, they're not city. There's no one that lives -- and this is a residential area. The people that live hundreds of yards away have homes there. There's new development there. There's development going on now, $300,000 houses, smaller homes, there's also generational homes there, farm land and homes that's been handed down from generation to generation. Those people have a concern about this facility, and I think it's something we should look at.

In thinking about there not being citizens of Johnson City, what we have here -- we think about taxation without representation. What we have here is implementation without representation. So if you would, think about that, please. The safety issues that we have, it's a very low crime rate. Low crime rate equals low presence in law enforcement. There's no need to patrol that area because we don't have needs and issues for that at the current time.

We're concerned about, the data that's been shown, about the traffic in that area. The traffic in that area is supposed to be, by the data that's been shown, the high traffic area is from 4:00

to 6:00 in the evening. 1.3 miles away from this facility is a high school that has 1,350 students in it. 70 percent of those students are coming right in front of that methadone clinic. If you think about that, that school adjourns at 2:40 in the afternoon. How could traffic time be between 4:00 and 6:00 when we have 1,350 students leaving that facility at 2:40? It's questions like that that we don't completely understand all the data because if one data set is not correct, it makes you question the other data set, and that's part of our concern.

Again, we have young drivers that's driving to and from school right there. To increase that traffic flow -- I wish that I can tell you that our students never text while they drive or they don't do any of this distracted driving and they're always focused on exactly what they're doing. So if extra traffic swerves in their way, they're going to be able to react to that. But we all know, and I can tell by the expressions on your face, that's just not the truth. It's not how things work. And our concern for our children and our concern for our community is just that simple. This is not -- this location has those concerns.

I wish I could tell you -- when I first

started out in first communications with this, I was convinced -- I would have stood before you today and said I believe in this facility, but not in my community. After educating and looking at myself and talking to people, there is a need for something to be done. After looking at this, I don't think this is the right thing to do and the people of Gray doesn't think it's the right way to handle this problem. Just because we have a problem does not mean that this is the answer to that problem.

And like I said, we think with other facilities with the government, with the national government, this is a Tennessee problem. This is a east Tennessee problem. This is a problem of the United States. And we don't believe that this is the right answer for this problem. Thank you for your time.

MR. DOOLITTLE: Thank you, Mr. Davenport.

MS. DAVIS: My name is Pamela Davis. I am a resident of Gray, but I'm also a physician assistant and I work in holistic medicine.

MR. DOOLITTLE: Could you speak up just a little bit, please? Thank you.

MS. DAVIS: I want to thank you for listening to our concerns because it has been weighing

very heavily on our hearts, and I thank Mr. Farber and Mr. Christoffersen for coming out and listening to us. When we talk about addiction, it crosses every part of a person's life. I think most people are affected by addiction. I think we've all seen it. I've seen it in my family. I've seen heavily in my family, different choices made, but it entails your body, your sole, and your mind. And I think that if we're going to treat the patient, we're going to have to treat all of those components because just the addiction part is not going to cut it.

So when I went through the 271 pages of the Certificate of Need, there's a lot of talk about wrap-around services. However, I could not find many specific details. None of the auxiliary services will be in the Gray area. Patients will have to leave the Gray area and travel to Johnson City, which is going to be a 25-minute commute for additional counseling, therapy, care management sources, social needs and employment basing housing. There's no public transportation in our area. Taxi services is very limited, and Uber is coming, but that's not going to fit their pocket book.

There's nothing laid out in the plans as the accountability for the patient. What is their

responsibility to this program? How much therapy? What is the goal of therapy? Where is the therapy located? Is it group? Individual? Who's in charge? And I couldn't find specifics. I was also unable to locate in there an application of new versus returning patients, no estimation of duration of treatment, no estimation of patient retention or attrition, no information concerning compliance requirements or what happens if they are not compliant, no information is addressed concerning patients already in a treatment program and transitioning over, or are they already on Suboxone? What if they don't want wrap-around services? What are the requirements of the patients?

There were no timelines for addressing patients getting off methadone, but I do think that if we're going to do a program -- and I agree; it's needed. There are issues that are important, and I think not only does the program have a responsibility, the patient has a responsibility. And how do we get them to engage in this and want to get better? Some people want to get better at addiction and some people don't. We've seen that.

It seems that everything is in the developmental stage. I didn't see much of an organizational structure. I went through -- on

page 54, the clinic is going to see 600 patients a day. This breaks down to 75 patients per hour. There will be two program physicians that's supposed to include physical exam, medical history, determine diagnosis, determine opiate dependants, ordering take-home privileges, discussing cases with team, issue emergency orders, and the onsite prescriber of services one hour per week for every 35 recipients. It works out to one minute seven seconds per patient. I do not know how that can be accomplished. You cannot give good care if it is that short.

Nurses will direct clinical care; and duties may include prescribing with supervision, charting notes, and facilitation and researching and administration. The last time I checked, nurses do not have a DEA number, and they are not able to prescribe medicine. So that would be a great concern. Who is going to be doing this? Who's going to be taking care of these needs?

We have heard several times from the petitioner that they would want to work with the community. The first time we learned about that was at the zoning commission just a few weeks ago, that they wanted to work with the community of Gray, so that was the first time we heard that. I would say they have a

lot of clinical resources. We were told that. Why are we not utilizing those? Why are we not utilizing what is already present instead of putting in a clinic, take what you have, and make the best of those uses? And why are we not talking to physicians and decreasing the problem where it starts with prescribing? Thank you.

MR. DOOLITTLE: Thank you, Ms. Davis.

MS. OLIVER: Good afternoon. My name is Sharon Oliver. I'm a certified professional medical coder. I'm a medical auditor. I have been in the medical field since 1964, one year before Medicare was put into place. So the white hair justifies what I am telling you, so I can prove it by that without my driver's license. I'm coming to you as not only on the professional side, which Ms. Davis is the PA here. I am not as educated as the professors and the physicians here. But I did a lot of OJT, on-the-job training, as a nurse for a pediatrician, family practice, practice manager for 13 years, 10 years OB/GYN, and the last 12 years ETSU positions in the associate's department of cardiology, so I've kind of been around.

But I want to talk to you as a mother, a wife of 53 years, a mother of three, and a grandmother of five. The impact of the location, as we have been addressed -- Brian addressed and all the students --

we've got three elementary students within a couple of mile radius. The high school a mile or so down the road. There's five private schools within this two-mile radius. Route 75 where the methadone clinic is proposed to be located is a little three-lane road with the third lane being the turn to go either way. No traffic light. We're only maybe a half a mile or so from the interstate. Yes, that's convenient for everybody. But the cross-traffic and everything, there's just not there.

The police say they can monitor it. I don't know. Can they set out there from 5:00 in the morning where people -- I have been in contact with pharmacists, pharmacy techs, that -- you know, the people camp out waiting for it to open. When a new doctor starts his practice -- and you can bank on it -- there's a new line of traffic setting out the door, and we call them seekers in the medical field, seekers. And that's what they're there for is to get that prescription to go home with being a new doctor and not knowing their history and all. So in this minute and seven seconds that we have per patient -- and that's only for 600. But a lot of places have 1,500 to 1,800 a day, Asheville and all. So tell me how -- you know, this is what the location -- the traffic pattern is

just not there.

And while I'll sympathize with the lady that lost her son, I'm a mother of an addict. She'll soon be 50 years old. She didn't become an addict until in her 30s after she had children of which the two we have adopted to save them. Woodridge was wonderful in helping her get over this. She has been clean now for about four years. The potential to go back is always there. Unfortunately, she didn't follow my lead. Mine was sour cream pound cake. Hers had to be something stronger. She survived it, and she did it through the determination that she wanted to; she knows she needed to. But death does not always mean that you're six foot under. It destroyed our family, it did. But I am so proud of her for being clean, and she got the help in Johnson City to get clean.

So I just wanted to point those things out to you as a mother and in the profession. I've seen it, you know. I've seen it. I've been on the ground floor. I've cleaned the bathrooms and wiped up the vomit and stuff from people. But we have -- our facilities are -- Johnson City Medical Center is, like, 11 miles from there. The gentleman here, I gave you a handout here of the 12 facilities in Tennessee, and you see that they are in a close proximity of medical

treatment centers.

Because when people take these medications and do these things to their bodies, respiratory distress, hypotension, systemic hypotension, we have cardiac arrest -- even though the ambulance is, you know, in the proximity of the building, we still got to get them, due to traffic and everything, 20, 25 minutes away where the care of the patient has always been in my focus. I take care of my doctor and my make sure the patients were taken care of so he could, and that is so important.

When you stop breathing -- my father died of cardiac arrest. When you stop breathing, you're done. And we need to have this, and I'm not saying that it's not a needed thing. Please don't ever get me wrong on that. But it needs to be in a location to where they can get the help in an acute distress situation. And in the area that is proposed, they are too far away, just too far away, you know.

And this medicine and they have to do a urinalysis and all of this every day. One tablet of methadone stays in the body for 59 hours, so they can get however much their prescription, one or two pills, whatever, and they get it every day. They could take one pill and still be determined positive the next day,

but yet they could be out selling the extras that they don't need. So these people are not dumb. They're smart. They figured this system out and to get what they want.

So I will close on that. So I just wanted you to know, I'm here to speak to you from the heart with nothing else involved from me but from the heart. Thank you.

MR. DOOLITTLE: Thank you, Ms. Oliver.

MS. WISE: Hello. My name is Debbie Wise, and I'm a resident of Gray, Tennessee. I appreciate you-all taking the time to listen to our concerns.

The first thing I wanted to mention to you is, I'd like to briefly address a couple of issues that the applicant made and the additional information that they submitted to you on August 15th. They talk about our concerns related to the school location and residential proximity to this proposed clinic.

The one thing that I would like to point out is that based on the discussions that they have had with other law enforcement officials with communities where these clinics exist, they are comparing Gray, Tennessee, which has a population of roughly 1,500. It is a census basis, so Gray has 1,500 census with no

local law enforcement there onsite. We are being compared to cities like Memphis with a population of almost 650,000. That's over 400 times the size of Gray. Knoxville has a census of around 179,000. That's over almost 120 percent the size of Gray community. Columbia, a population of 35,000. Dyersburg, 17,000. Those are 12 to 25 percent the size of Gray, Tennessee, with services and locations right there that may be needed by the patients that would come to the clinic.

The other thing that I would like to point out, you have a map in front of you that shows the boundaries of Johnson City, Tennessee, and the area that has been annexed in past years. The red triangle represents where in Johnson City this clinic is going to be located, and it is far away from the city of Johnson City. It's about 10 miles. I travel it every day going into Johnson City to work. So I would just like to point out that people that live in the city expect things like this, but people who choose to live in a rural community don't expect certain types of services to be there and available.

Going onto the -- to the Certificate of Need. As I read through that, I do think it is a very appropriate idea to have a nonprofit holistic treatment

center. However, my concern is that the applicant doesn't have the experience or expertise in operating a nonprofit substance abuse treatment center. They talk about this being a new project. And while it's very worthy, I would just like to point out that there's many unanswered questions relating to how this is going to transpire, how the clinic and ETSU are going to be operate and be funded.

Throughout the CON, they elude to that fact in many of the responses to the questions with answers like, the project represents an opportunity to develop something, a comprehensive model. An innovative model will be created. The program is in its developmental stage. We plan to engage some external experts to supplement any knowledge gaps that we have to operate this type of clinic.

So in the additional documentation that they supplied on August 15th, they state that there's no real data for the specific type of facility, so there are questions that need to be answered. The applicant also states in the supplemental information provided Mountain States' long history of providing inpatient and outpatient of treatment of alcohol and drug abuse patients at Woodridge psychiatric hospital is the basis for the expertise for operating the

proposed clinic.

So I think it's important to look at what is the success rate that they have had in treating patients specifically with opiate addictions, what are the re-admission rates for those patients both from an inpatient perspective and in their intensive outpatient treatment centers that they have.

Also, regarding the financial data, they state on page 50 that the patients will be charged $13 a day for treatment estimated to provide $3.6 million in gross revenues by the second year with a net income of 950,000, and that the positive income from that would be re-invested into the large center, which is ETSU's research facility, and then that this is earmarked for ongoing research and evaluation to identify additional evidence-based approaches.

You asked the question about the -- incorporate the -- regarding the incorporation of additional components -- the clinical training, the community education outreach, research -- and the applicant states that it's not the intention to use the $13 a day to support and subsidize those services, that the center has obtained grants. One of those grants is scheduled to expire in March of 2018 to the tune of about $2 million, and the other $3.5 million that they

refer to as being supporting this research and these other components of the treatment are in the review stage. So they don't even have secured funding for that $3.5 million. So if that's the case, how do they plan -- if those grants are not funded, how do they plan to subsidize the additional components of treatment? Is it going to be this money going back over there to fund the research and everything?

And so I do think that it's a very worth while cause, and as you can tell from their maps that they put up earlier with all of the facilities that they have throughout those counties, I see a great opportunity for them to be innovative and take this to the patients instead of making the patients come to them in this rural community of Gray because where it's located there, you still have a good 45 minute to an hour drive from many of the places that people would come to from those surrounding counties. Thank you for your time.

MR. DOOLITTLE: Thank you, Ms. Wise.

MR. LARKY: Good afternoon. My name is Mark Larky, and I live in Gray. I also have the privilege beginning my 11th year as a member of the Washington County Commission and also a member of the Washington County Planning Commission. My comments

reflect the many fine views of the Gray community which I proudly serve. I will briefly provide remarks under the three criteria in which you consider.

First of all, is this clinic located at 203 Gray Commons Circle needed? I would begin by saying that we all tend to provide and magnify data, statistics, and studies that support the outcome that we are seeking, and it appears to me that this is the approach in the Certificate of Need by the petitioner.

In the CON, it states that Tri-Cities Holdings, LLC, was denied an application at your June 26, 2013, Agency meeting. The application was for the establishment of a nonresidential substitution based treatment center for opiate addiction preventing symptoms of withdrawal. The estimated project cost was projected to be $670,000. Your reason for denial was the following:

The application did not meet the statutory criteria. You stated that there was not a need for this service as there were effective treatment options available for opiate addiction in our area. So I submit to you that this board addressed the question of need, and there have been no significant changes. Can you hear me okay?

Secondly, can this proposed clinic be

economically accomplished and maintained? Many have said that the approval of this request or requests similar is actually a license to print money. I'm a capitalist through and through, so I have absolutely no problem with profitability. This business will be economically sound, which supports the reality that anything less than the ideal location and model should not be accepted by you as a board. I strongly state that this is not the best location for such a facility. This was evidenced by the mayor of Washington County, Mayor Eldridge, and Mr. Collier, the realtor for the applicants and evaluation of 40 potential alternate sites after a public hearing and the applicant realized how much opposition there was.

We never had opportunity to discuss other sides prior to that. Reasons stated to me for the rejection of the many sites were supposed problems with the investment amount and by some problems with the Johnson City parking requirements and their zoning code specifically for methadone clinics that were designed to make locating these facilities difficult. There were more suitable sites submitted by Mayor Eldridge of which some required no rezoning and ultimately were rejected by the petitioner with the only rationale was that it exceeds budget.

We contend that there are better alternatives and you have a business with a profitability that this one has, you should locate it in a better location. I would my business, and I think you-all would as well.

Also, the CON states that the Gray Commons is a plan multi-use commercial development site envisioned by the city of Johnson City and Mountain States Health Alliance as an economic development driver for the Gray, Tennessee, community. Well, they are proceeding to fulfill their economic vision for Gray by proposing to open a methadone clinic. The citizens of Gray certainly do not want our economic vitality to be dependent upon the operation of a methadone clinic, and I don't think you would in your community either. So we respectfully disagree with their envision of the Gray community.

Lastly, will this proposed clinic contribute to the orderly development of healthcare? Well, when considering this question, many items affect the term orderly development; perhaps none other, the location which we just discussed. Specifically the methadone clinic's location in regards to compatibility to the proposed surroundings and acceptance from the community, therein lies a tremendous problem with the

question os orderly development in relation to this proposed location by the petitioners.

If you'd allow me the privilege to quickly share some information I believe will be of interest to you in terms of our local zoning, because they are not uniform throughout the state and some of you may not be familiar with Johnson City and Washington County. The city, Johnson City, currently has a zoning designation in conjunction with the special exception from its board of zoning appeals to accommodate nonresidential treatment facilities which allow for the dispensing of methadone.

The city of Johnson City and the Johnson City Planning Commission, in 2015, altered some of these regulations in the MMS-1 zonings specifically to ensure these facilities had areas to operate in if they met certain criteria. The proposed site in Gray is zoned B-5 under the city's zoning designation. That's prohibiting methadone clinics. There are zero MS-1 zonings in the Gray area, and the surrounding properties of the proposed clinic are predominantly county properties zoned R-1, which are residential, and A-1, which is agricultural.

There are very few -- and I emphasize "few" -- surrounding city zonings are B-5 business and

A-1 agricultural. It's very important to note that the nearest current MS-1 city zoning is on Knob Creak Road in Johnson City, a significant distance from the Gray site in the Gray community.

We would submit to you that this clinic with its use is completely out of character for the proposed site, and one city planning commissioner noted in the Planning Commission that it appeared to him that this case was spot zoning. I quote that.

I haven't even began to discuss the tremendous residual burden this will place on service delivery to the extreme outlying area for Johnson City, which will be substantially impacted and even spill over into county services that would be affected adversely. Johnson City's own Chief of Police stated at the Planning Commission meeting stated the clinics in Knoxville, which he visited -- he said, I quote, not close to residential areas in Knoxville, not close to residential areas in Knoxville. That's not my statement. That's the Police of Chief in Johnson City. Friends, this location is surrounded by residential and farm land.

In closing, I would like to return to the denial of the Certificate of Need for this type clinic in our area by this board in 2013. There have been no

perceived or stated massive increase in the instance of opiate addiction since 2013, nor has there been any decrease in the availability of treatment for these addiction problems since 2013. Therefore, this board -- your decision -- this board's decision in 2013 was valid then and certainly remains valid today. I proudly stand here as a representative of the Gray community and respectfully request to you to deny this application in its present form with the address being 203 Gray Commons Circle as its desired location to operate a methadone clinic. Thank you very much.

MR. SELLS: Mr. Chairman, I would respectfully request an additional five or six minutes, and we'd gladly agree to the petitioner having the same.

MR. DOOLITTLE: Yeah. Thirty minutes has been used up, so we do want to hear from you. I would encourage you to be concise.

MR. SELLS: Mr. Chairman, members of the committee, I am Danny Sells, and I am a 63-year resident of Gray. We appreciate the opportunity to expression our strong opposition today to this proposed methadone clinic right in our rural residential and agricultural community.

First, I wish to thank the staff of the

HSDA for coming to our community to let several dozen of our citizens express their opposition without traveling to Nashville today. Mr. Farber and Mr. Christoffersen, we're very gracious, and the entire staff has been willing to assist whenever we had questions.

As a continuation of my community's strong opposition, I wish to offer to HSDA a copy of our petition, which today numbers 2,073 residents of Gray, folks that have children attending schools there and many commuters that pass through Gray on Stone Crest Drive by this site each day going to work.

Yes, there have been about 30 letters of support largely from individuals in groups associated with Mountain States Health Alliance. They are largely from a form letter or press release because most start with a similar statement and list a commentary out of statistics that is repeated in the application. I will point out no letter -- I will point out that no letter I have seen yet indicate Gray as the best site for such a facility. Only one says that if it is not the best site, then another site needs to be selected and approved immediately.

Additionally, a letter from the District Attorney General of Sullivan County support lends

support if nine bullet points are met. Unfortunately, almost every point is contradicted by the application itself; and I assume that if the general were to read the application, he would not support this clinic.

I would like to take a moment to show you the map, and I will do that quickly. I'm not sure if this will actually -- it won't. But several folks have mentioned how far away Gray is actually from the city. The lower portion toward the bottom is actually where downtown Johnson City is, where the police department, municipal and safety building is. Gray is that strip way at the top, and a little ways out is actually where that facility is actually located. The hospitals are back into Johnson City itself, and that's just to represent.

This map, I just felt, offered a real good opportunity for you to see that this is a bit of an anomaly that we are actually on the way outskirts of Johnson City and not really even at the edge of Johnson City. Why is this important? In the orderly development of healthcare, a facility must have the support structure to even have the possibility of being successful. Hospital and police services are 10 to 12 miles away and can be up to 25 to 30 minutes away even in an emergency. As others have stated, other such

facilities in Tennessee are located within the city proper and within two miles of the hospital. And as demonstrated by this community, this type facility will never be accepted even if forced, and no business is ever successful located in a hostile environment.

The community is not without compassion for those in need, but we know for certain this type of business has no place in our rural residential and agricultural community.

I would like to speak for a minute to the application. Mountain States is currently in the middle of a massive merger with Wellmont to provide medical services in east Tennessee and southwest Virginia. This is their main business and should have their full attention. Mountain States and East Tennessee State University have, on numerous occasions, stated both in public and to the press they are proposing this methadone clinic because they were asked by local elected officials. With these statements and the pending merger, why would any of us have any degree of confidence they have a full commitment to running a successful methadone clinic, a type of facility of which they have no experience?

Additionally, I've read the application numerous times and keep going back looking for more

explanation of what they are actually going to do at this facility, and I have listened to their comments at every meeting read every press release and only find changing statements and contradictions. Their responses mostly say "We will do that" or "Both of these items will be covered." Basically, the idea of just trust us. They say nice things like holistic, innovative or national model, but without explanation, those words are hollow.

Unfortunately, it just reads like another full-profit clinic; and if they fail to make this clinic more, then our community is left with the nightmare it fears. Surely this orgulous body charged with ensuring the appropriate delivery of healthcare in Tennessee expects more than offered by this application. I do believe these are good people with good intentions. People I trust have good things to say about Dr. Pack, Ms. White, and others. But this application was rushed, by their own admission, and unfortunately, it has never been approved.

Given the building national emphasis on this addiction problem, one can see major shifts in improvement beginning, which will quickly change the approach to this problem. But I fear this application is an old approach at the tail end of an old solution.

But the opportunity exists to utilize the excellent resources available to them in the northeast Tennessee area such as the ETSU College of Medicine, experienced clinicians, the larger medical and educational community, and to use a newly developed regional healthcare organization through this merger to provide reasonably accessible services and multiple medical facilities across the entire northeast Tennessee and southwest Virginia area.

The medical industry wants to treat this as the medical issue and that it should be approached in a medical setting. This approach would significantly reduce travel time for clients, reduce public safety concern on our highways and communities, and eliminate the stigma of using a facility not only for treating addiction. This is one approach, but the resources are there to make this truly innovative, treating the whole patient in a medical setting and including those additional services to help that client become drug free.

We plead with you to send this application back to the starting point where a better approach can be developed that we will match the challenge existing in northeast Tennessee and southwest Virginia. We deserve better, and they are capable of

providing a better approach. Thank you, Mr. Chairman.

MR. DOOLITTLE: Thank you, Mr. Sells. We have rebuttal by Mr. Elrod, and you have at least 11 minutes if you feel you need that.

MR. ELROD: Mr. Chairman, this is Dan Elrod, and I'm actually going to try to not use all of that because I know the Agency has been through a lot already.

First, in regard to -- I mean, I don't want to weigh too much into the location because I understand that the Agency is not a land-use body. You've heard a lot about the location, so I want to say a few things about that. One is just -- I mean, this site is a commercial site. It's an office building on 38 acres, and so it's not like just stuck in the middle of a subdivision. It is on 38 acres in an existing office building.

With regard to safety and how that -- in terms of proximity to emergency facilities, it's right next door to a fire hall with EMTs, and it's half a mile from an EMS station. So the idea that somehow the patients are going to be stranded out there without access to emergency services is just not the case because of the proximity of emergency care right there at it.

The Johnson City Planning Commission recently took this site up as a matter to consider, and a report was rendered to the Planning Commission by this department within Johnson City Government about the safety issues, et cetera, and has already been eluded to. The Chief of Police in Johnson City spoke to officials, law enforcement officials, in Memphis, Knoxville, Columbia, and Dyersburg. There were little, if any, crime spillage from this clinic's sites in [inaudible].

I also make the point that there was some opposition in some location of the clinics, but the concerns have not come to pass; and we suggest that will also be the experience here because that's been the experience in other places in Tennessee, and it's just not an issue. We passed out today, I think, an article from the Knoxville News Sentinel, which coincidentally, the Knoxville Police Chief once again re-iterated that these do not create any kind of additional crime in the vicinity.

I think it is important to clarify one thing about the patient load, and comments have been made about how can you possibly, you know, see that many patients with the staff you're talking about? And just to clarify, the number of patients that are

identified in the projections are the number of enrolled patients. That's different from the number of patients who will be seen every day because as a course of treatment evolves, patients come less and less often. So the number of patients there every day is significantly less than the number of enrolled patients. And so that, I think, addresses the concerns about staffing. You can't just do that math that was done by the opposition to come up with those numbers.

The other concerns addressed in terms of the operation of the facility are, in fact, addressed by licensing standards and licensing requirements. These facilities are licensed by the Department of Mental Health of Substance Abuse Services. There are multiple pages of licensing standards that have to be adhered to in order to maintain a license. In addition to that, there are federal requirements that have to be adhered to. So in terms of the dispensing, looking after patients, the care plan, the follow-up on patients, what you do with a patient if a patient is not compliant, all of that is addressed by state and federal requirements.

One other thing about the traffic while I'm on the location -- I meant to make this other point. The same Planning Commission -- and this

department did this work with the Planning Commission -- looked at traffic, evaluated traffic volumes along the roads, et cetera, included that the anticipated traffic characteristics of the proposed clinic will have no significant impact. So traffic is not a problem by the body that's in charge of studying that.

There's some criticism in the application because there's not full development of all the additional services that would be provided in this project. I think Dr. Jessee actually did a great job of summarizing all those services are, which they already have in place, but you can't fully develop that in a proposal until you have approval to proceed. You can't -- that would not be good stewardship of nonprofit dollars to spend a lot of money to fully flesh out this clinic unless it's approved. So this is the first step towards that; and Mountain States, ETSU, and Frontier are committed to do this and use our resources to make it happen in the appropriate way.

One clarification about the additional services: As Dr. Jessee explained, some additional counseling-type rehabilitation recovery-based services will be provided in the clinic itself. There's a standard amount of services that have to be provided in a clinic. But the more robust recovery-based services

will be provided through Frontier at its disbursed locations throughout, and they cover all the counties that are in this primary service area. And so the patients who access the more elaborate and more focused counseling services will actually do that closer to where they actually live as opposed to all coming to the site in Gray for all of that.

With regard to the 2013 application, I don't think I need to tell the Agency because the Agency has told me this a number of times, that every application rests on its own merits and the action on one application does not establish any precedent as regard to another application. And on that point, this project before you today is far different from what you considered in 2013. It did not involve this collaboration and the access to the full array of services that are proposed in this application.

We hope we have fully addressed all the questions the Agency might have, but I suspect we have not, so I'm going to be quiet now. And we have a number of people here to answer any questions the Agency may have.

MR. DOOLITTLE: Thank you, Mr. Elrod. It is time for questions from members.

MR. CHRISTOFFERSEN: Mr. Chairman, may I

before --

MR. DOOLITTLE: I messed up again.

MR. CHRISTOFFERSEN: May I say something? I don't normally jump in so much for good reason, but I did want to point out for the members, as questions, on very specific bit of guidance is, I'd suggest staying away from the issue of zoning specifically because Johnson City's zoning ordinance is currently being challenged in federal court, and so therefore we don't have any evidence that anything having to do with Johnson City's zoning will preclude this project being completed. So I just wanted to recommend that since it's in federal court, we just leave that be.

MR. DOOLITTLE: Thank you, Mr. Christoffersen. Questions for members? Mr. Mills.

MR. MILLS: Okay. This is a question for the applicant. Ms. White, I believe you said you live in Gray? You need to come to the podium, please.

MS. WHITE: Yes, sir. I live -- I'm a current resident with my family in Gray.

MR. AUSBROOKS: State your name.

MR. MILLS: Okay.

MS. WHITE: Lindy White. I'm sorry. Lindy White.

MR. MILLS: Help me understand. I mean,

I've heard it's a two-lane road. I've heard it's a three-lane road with a turn lane. You are a half mile off the interstate. Can you give me a little more insight? I mean, is it heavily trafficked?

MS. WHITE: Sure, sure.

MR. MILLS: I mean, school traffic in the morning and school traffic in the afternoon? Because I've heard the population in Gray is 1,500, but there's 1,500 at the high school, I think, or close to it. So I'm getting confused on some numbers.

MS. WHITE: Well, I think really -- one really, really important point here in regards to the traffic patterns in Gray is that we currently just most recently have had kind of a robust development and construction phase of the on-and-off that you mentioned on I-26. So it, through that construction development project, has certainly addressed any issues with the on-and-off as it relates to the interstate.

And so I do have a son at Daniel Boone High School, which is one of the schools referenced here. And of a 15-year-old, I'm still a mother who drops him off every morning, and it's a very well-developed road, double lines. And if you could see a picture of this facility, the facility, while on that main two-lane road, as you're coming towards the

schools that were referenced here earlier -- very, very nice developed road, side shoulders. And our current facility actually sets a good distance off the road. It's not setting right on the shoulder of the road. In fact, if you blink, you would miss it. So with that, I would say that dropping my child off at 7:15 in the morning is no issue. And, certainly, as you-all may or may not know with this proposed project, there's really three periods of time where there could be an increase in traffic patterns. And typically, again, our project are going to serve those patients that are working.

Typically, there's a burst. There will be a burst of traffic from probably the 5:00 to 7:00 period of time before patients go to work. Likely, probably the second period of time, based on the studies that we've done with one of the larger operators of these sites, would be just before lunch, again, while the schools are in session; and then most likely right after lunch, before we close at 3:00 p.m., which would be before, you know, before the traffic and congestion starts.

School there at Daniel Boone High School does release at 2:45. Typically, before my car pulls out on the site after the bells ring is 3:00 p.m. I usually typically if I'm the one picking him up, which

is rare, 3:30, you know, really before I get back home to my resident, which is just a few miles from Gray. So very well-developed right off the interstate, a development construction project to address those concerns.

And, again, I think one major plan I want to point out, if you look at the site that we were asked to consider, which we did, and you compare the residential dwellings of that location on Oakland in the middle of Johnson City to the site that we're proposing in Gray, the number of residential dwelling's a half mile and the Oakland site is 719. The actual number of residential dwellings, again, which does obviously contribute to the traffic concerns in Gray Commons is 217.

So the proposed site in Johnson City double, and if you look at the residential dwellings a mile, it's almost triple. So, again, just speaking about the traffic patterns personally, I feel like -- and, again, the independent studies had been done, we would not be asking to locate this site if we didn't feel like the traffic patterns and the roads could adequately and safely deal with additional traffic associated with our project.

MR. MILLS: In regards to a local law

enforcement, I assume it's governed by Johnson City or Washington County?

MS. WHITE: Yes, the City of Johnson City.

MR. MILLS: Okay. Okay.

MS. WHITE: And there's also been an independent study by the Chief of Police of Johnson City who also weighed in on that, and you should have that probably available in front of you.

MR. MILLS: Okay. And, you know, I understand you're going to ramp up on these 60 patients. Is that going to be like an average census population on an annual basis?

MS. WHITE: Yes, sir. So when the first year that was referenced earlier, 650 -- an important point here -- that is the number of patients enrolled by the end of that first year, and we will ramp up certainly to that number. That is not the number of patients seen on a daily basis. The numbers are less than that as patients progress through their treatment plans. So it's very, very important that -- you know, we estimated Dr. Jessee, who's much more of an expert on that piece as far as counseling and case management -- he's much more of an expert on that.

When we looked at the studies -- and we

looked at, you know, approximate examples. We feel firm and stand firm on the fact that our staffing models as compared -- and we have researched with multiple other clinics, that we have amble medical licensed counselors as part of our project to deal with this patient population. We're anticipating somewhere between 240, 275 patients daily once the first year gets ramped up to the 650 enrolled. That's a very, very important point.

MR. MILLS: And I think for the citizens, security is a concern. And from what I read -- if you'll just confirm this in the application -- I didn't earmark what Bates stamp number it was. But you're going to have security onsite during the business hours; is that correct?

MS. WHITE: Absolutely. We're going to have at a minimum two officers onsite during the hours of operation. And in addition to that, as you-all can imagine with our 13 hospitals and pharmacies we run every day, we'll also have 24/7 monitored security surveillance in addition to the onsite officers that will be onsite when the clinics open seven days a week.

MR. MILLS: So if someone showed up at 4:00 to get in line on Monday morning, they would be under surveillance?

MS. WHITE: Absolutely. Yes, sir. Monitored surveillance, absolutely.

MR. MILLS: And then one of the things that has been mentioned over and over and over again -- and I'm not convinced of this, so I would like for you to speak to it. I'm not sure how often the clients who would treat need emergent care when they walk in your facility or care that they can't be transported within a reasonable amount of time. Because, you know, that area of Tri-Cities, there's a lot of rural area in order to get to a hospital not just, you know, 11 miles down the road.

So do you have any statistics or experience or history regarding how many -- percent -- would need emergent care when they presented in the facility?

MS. WHITE: So a couple of things. We kind of addressed that on a three-legged stool. A couple things we've done, which Dan addressed earlier in regards to the medical personnel that are available around the site. Not to mention that we'll have a medical director and licensed medical folks will be onsite at our when it's operational. There will not be a moment when someone's not there that's not licensed to deal with a medical emergency.

In addition to that, we have worked closely with one of the largest operators of recovery-based treatment centers in the nation. They have 38 sites, and I've been in close contact with their operator. They site that emergent medical reactions related to this medication assisted therapy has not been a problem at any of their 38 sites. Now granted, this is much like -- and the way I would frame this up and the way it would look to you-all if you-all were to walk into our clinic would be this is going to be much like your visit to your family practice physician. We operate many outpatient practices within Mountain States Health Alliance and we, of course, want to have the appropriate medical equipment and personnel there ready and able to take care of any medical emergency.

So those two legs of the stool, we stand committed to that in addition to err research because we don't -- this is a new -- this is a new tool in our tool kit. Research demonstrates that medical emergent reactions to this type of treatment is not common, and we will have the available folks there in and around, as we spoke to, to deal with any medical situation and to get them to the closest medical facility which based on -- which is my other community hospital located in

Johnson City, which is about nine miles away. So we feel very, very comfortable that we can provide a safe model with this type of treatment in Gray.

MR. MILLS: That's all I have, Mr. Chairman. Thank you.

MR. DOOLITTLE: Thank you, Mr. Mills. Other questions? Ms. Jordan.

MS. JORDAN: Is there a goal as part of the comprehensive plan of care to whine patients off of methadone or what -- I think that has been a concern in the past that --

MS. WHITE: Yes, ma'am.

MS. JORDAN: -- there's just a substitution of one -- an addiction to one drug to another. So my question is, what is the goal here?

MS. WHITE: So let me firmly say the goal of this clinic is certainly recovery, and the end goal in sight is abstinence eventually with our patients. We feel the not for profit brings that to the table with a commitment to have a recovery-based abstinence-based program. Now, granted, as was noted earlier, every individual patient is different. Some will get there in a year. Some will get there in multiple years, but we are committed to that model, you know.

I just want to emphasize that our model is different for that reason. Our patients will have the goal of recovery and abstinence as a goal. Methadone, too -- and, again, I'm not the expert. I'm not the clinician in the room, but methadone can be easily tapered one milligram at a time. And so that will be, you know, obviously up to the medical director and the physician. But methadone honestly can be tapered very easily as a medication-assisted therapy, and that would be the goal is to taper our patients as would be medical assessed and deem necessary.

MS. JORDAN: Okay. A couple of other questions, just some issues that were raised by the opposition. I believe it was Ms. Oliver suggested that there's certainly opportunity for people to get medication that they don't necessarily need and then sell it on the street. What type of safeguards are in place, or is this -- talk to me about that. What's your response to that?

MS. WHITE: I'm going to let Dr. Jessee -- is that okay?

MS. JORDAN: Yes.

MS. WHITE: One thing I will say, it is very well-defined in the state regulations as far as the diversion plan, and we would certainly have at in

our clinic. I'll let Dr. Jessee expand on the details.

DR. JESSEE: Randy Jessee. The dosing process with methadone is very prescribed. The initial dose can be no more than 30 milligrams, is written as an order by a physician after that physician has conducted a physical exam and the history process with that particular client. And that can take up to an hour and 25 or 30 minutes in order to do that. That first dose is not administered until that physician is ready to do that, and then that initial 30 milligram dose is administered.

Then a time frame of anywhere between three and four days happens and as a person that's coming in every day, only the physician can change that milligram that was previously given. And so if the first day was a 30 and the second day was at 35 and then the fourth day was at 40, then that process is always done and administered by the order of the physician. So the physician has to see that and make that determination. A nurse cannot do that. Another clinician or therapist cannot do that. Nobody else in the facility can do that.

They're prescribed rules and regulations for the diversion of any medication. All medication in a methadone facility has to be locked in a safe and

monitored in double fashion with cameras and other safety devices on the safe itself. Every day there's double counts of all medication. And the process over time for a patient to receive any take-home is, I believe, at this point the regulations -- I don't have it right in front of me. But the regulations do prescribe that you have to be in treatment -- stabilized in treatment at least one year before you get -- and on an emergency basis approved by the physician, then only one day take-home could be given to an individual on a Sunday.

MS. JORDAN: Okay. So do I understand correctly that in most -- because I'm not a clinician. This is not my area of expertise. So people actually receive the medication and take it at the clinic?

DR. JESSEE: Yes. It's all done onsite. Nobody walks out with the medication unless they have progressed beyond the point where -- now, there's some people that will do that over extended periods of time. They have to be very stable individuals -- stabilized -- on the medication stabilized in the recovery -- in the therapy part of it and, you know, presenting themselves as, you know, citizens.

MS. JORDAN: Okay. That's helpful. And then, Dr. Jessee, I don't know if this is a question

for you or someone else. I believe Ms. Wise was the one who raised a question about future funding of the various wrap-around services. Maybe a question that that hadn't been finalized. Can someone address that?

DR. JESSEE: Sure.

MR. PACK: Hi. Robert Pack, ETSU. It's important to recognize that there are multiple sources of funding for any of our staff. It could be state funding. For example, I'm paid largely through state dollars and grant dollars. It could be clinicians, you know, make money through a practice plan or something like that. So there are multiple sources of funding. We even have some donations that have funded some Naloxone distribution. So there are multiple sources of funds and staffing.

And for our research program, we have multiple grants under review, you know, in any given year. Unfortunately, our three-and-a-half million-dollar project probably won't be funded. We got our score, which was just outside the funding range. It's unfortunate, but we were encouraged to actually go back in for that particular award as with a slight modified proposal, which we intend to do.

That's specific to our research program, and that grant was actually to do a rural addictions

network which was to grow basically the quality and scale of access to medications to treatment in rural areas using providers that already exist there, so we're actually trying to enhance the quality because there is a fair amount of Buprenorphine diversion that's happening and we were trying to get people engaged with a high quality of care through that proposal. But it's not pertinent to this application as part of our larger set of activities that we have ongoing at any given time. And there are a number of others. It could be a research project on pharmacists, for example, or an education program, things of that nature.

MS. JORDAN: Okay. Thank you.

MR. PACK: Does that help?

MS. JORDAN: Yes. Thank you.

MR. PACK: Okay. Now, comprehensive services, the wrap-around services, are more clinical. Those are actually with Frontier and Mountain States.

MS. JORDAN: All right. Thank you.

MR. PACK: Sure.

MR. DOOLITTLE: Thanks, Ms. Jordan. Other questions?

(None noted.)

MR. DOOLITTLE: Seeing none. Summation.

Would someone from the opposition -- you have an opportunity to speak for three minutes summarizing your position. Mr. Sells.

MR. SELLS: Danny Sells. Mr. Chairman, I request an hour. You know, in summary and to respond to a couple of things that is important, I think, to understand why we have so much concern about this application and whether it's very thorough.

Actually, Mr. Jessee contradicts Ms. White when it comes to the patients and the amount of time that they're going to be there and whether there's going to be 650 every day or 1,000 every day, not to even include the fact that year three, they start providing Buprenorphine or Suboxone, which will increase the number of patients. You know, my understanding was it was less than a year that they could actually start taking it home, but I'm not a clinician or trained in it. I just can understand what I read.

The concern is too that even though this isn't developed, there are being many grants request proposals written. Every grant proposal I've ever written requires some pretty specific details for what you're going to be doing, and I would anticipate that this application ought to provide more detail than what

is being provided here.

The time of service -- we've been told pretty well all over the board as to what time the services would be provided, and another set of times were indicated here today.

I will say that Gray is a census designated area. The population in Gray in the 2010 census was 1,222. We are probably in the neighborhood of 1,500 today. The area surrounding our community, in this little thin strip that I pointed out over here, if you literally walk across Highway 75 or Suncrest Drive from the clinic itself, it's only about 100 feet off of that highway. You are literally in the county. It is surrounded by county. Yes, there's 36 acres that actually Mountain States owns, but there's all of this county around it and very confusing jurisdiction on who actually responds.

Even in some of the hearings we've been in, there has been concerns between jurisdiction, between county and city, between simple things such as an accident in some areas. I'd also mention that Ms. White actually lives on the opposite side of Interstate 26 over on Free Hill. That is not the side of the interstate that this particular clinic is proposed to be on. Those of us who live on that side,

the side where this clinic is proposed to be, understand exactly how it is trying to get out on that highway at 7:00 to 7:30 in the morning upwards to 8:00 or 8:30. You very often -- I did just last Friday had to go the opposite direction of the way I was going to go because as far as I could see, there was no brake for me to get into the traffic, so I had to take an alternate route. I understand that maybe when she gets in the traffic, it's not a real problem getting her student to Daniel Boone. But for us that travel that road daily whether it's to work or whatever else, it is a clearly different situation for those of us that live on that side of the interstate.

I will also say, too, that we are not specifically concerned about crime or how people act onsite.

MR. DOOLITTLE: Mr. Sells, your three minutes --

MR. SELLS: We are concerned about how people act when they leave and who has the jurisdiction to help our community with that once that occurs. Thank you.

MR. DOOLITTLE: Thank you for your comments. Mr. Elrod, three minutes to you.

MR. ELROD: Thank you, Mr. Chairman and

members of the Agency. Dan Elrod on behalf of the applicant. Just one quick point about the traffic, part of the report done for the Planning Commission basically said, for comparison purposes, "The proposed clinic would generate approximately half the traffic of a typical fast food restaurant or one-fifth of the traffic generated by a coffee/doughnut shop during the AM period," so this is not a significant generator of traffic.

The other thing I'm going to do really in my summary is simply quote from the report by the Department of Mental Health on this project. "One, the need for residential opiate treatment program is part of a comprehensive approach to opiate abuse and dependents in the proposed region has been reasonably established.

Two, the proposed project appears to be economically feasible. Proposed staffing meets or exceeds licensure requirements and proposed salaries are consistent with the market rates.

Three, the application for a nonresidential opiate treatment program as part of a nonprofit corporation operating a center with a comprehensive approach to prevention and treatment of drug abuse would contribute to the orderly development

of healthcare in the state of Tennessee. As proposed, the nonprofit East Tennessee Holdings, Inc., would combine the established healthcare delivery organization Mountain States Health Alliance with the academic and clinical expertise of East Tennessee State University of which the OTP would be one service.

The proposed partnership with Frontier Health would establish the important relationship with an existing provider of comprehensive community mental health and substance abuse services and improve access to a range of substance abuse treatment to Tennesseans in this region struggling with opiate abuse and dependents. I think the Department of Mental Health summarizes it better than I can. We urge the Agency to favorably act on this application.

MR. DOOLITTLE: Thank you, Mr. Elrod. It's time for discussion by members. Mr. Mills.

MR. MILLS: Well, you know, it's not always easy to have to address those that are opposed, but I think that -- with the collaborative efforts of all three entities, I think that they have done a great job in doing studying and researching and continue to do so if approved to find a more innovative approach to a solution if there ever is a solution. So I do plan on supporting this application.

MR. DOOLITTLE: Thank you, Mr. Mills. Dr. Fleming.

DR. FLEMING: I would echo Mr. Mills' comments. From a physician's perspective, the question of does it meet the criteria for need is almost comical in our state. I mean, we're so far off the charts in need. This is a drop in the bucket, but I think it's an excellent drop in the bucket, and it's a way forward that we'll do something more creative and more innovative and I really applaud the efforts.

I need a little clarification. You say not to mention zoning and now I'm going to do it just for clarification though. If somebody changes the zoning on this applicant that's being questioned, so if we approve this and the zoning gets reversed, then our approval doesn't matter? I just need clarification how that works.

MR. CHRISTOFFERSEN: Normally in Certificate of Need applications, the Agency and its staff, before even deeming an application complete, requires site control. That's why we have contracts. That's why zoning needs to be either in line or look good or what have you. But given that, A, it looks like they're on the right track to begin with to have zoning approved. But even if it weren't approved,

since the zoning ordinance for the City of Johnson City is under appeal in federal court and there's nothing definitive from the federal court yet, I suggest just not even factor in zoning.

DR. FLEMING: To move ahead as if it's not a problem?

MR. CHRISTOFFERSEN: Exactly. And if it gets stopped in its tracks, it gets stopped in its tracks but not by us.

MR. DOOLITTLE: Anything else, Dr. Fleming?

DR. FLEMING: No.

MR. DOOLITTLE: Okay. Other comments? Ms. Jordan?

MS. JORDAN: No.

MR. DOOLITTLE: Anybody else?

(None noted.)

MR. DOOLITTLE: Seeing no additional comments, we would look for a motion. You're smiling, Ms. Jordan.

MS. JORDAN: Mr. Mills has his hand raised, but I'll do it if you want me to.

MR. DOOLITTLE: Mr. Mills.

MR. MILLS: In regards to East Tennessee Healthcare Holdings, CN1605-021, for the establishment

of a nonresidential substitution treatment center for opiate addiction, I make the motion to approve this application based on the following criteria being met:

Orderly development of healthcare. There are no opiate treatment programs in the eight-county service area. The closest OTP is in Knoxville over 100 miles away and in North Carolina 45 miles away. This program will reduce prescription drug use and drug abuse in the area. This program will provide the needed education, outreach, research, treatment, and evaluation in partnership with the ETSU research foundation. It will provide needed education for students and interns training in the medical field.

It is located within one mile off of I-26 in Gray providing ease of access to patients in the eight-county service area. They will be using evidence-based therapies to reduce the dependency of drug addiction.

Regarding need, this project will prevent the need for patients to have the burden and hardship of traveling outside the service area to receive needed treatments. It satisfies the need for an innovative approach for prevention and drug dependency populations. With an estimated patient census of 650 in year one and 1,050 in year two, it will provide

convenience for these patients to be within closer proximity to where they live.

This project by design will provide more efficient high quality of care with their collaborative efforts in partnering with East Tennessee State University foundation. With the upper east Tennessee among the highest in the state for struggles with heroin, morphine, and prescription opiates, this project will serve the need to reduce these dependencies.

Regarding economic feasibility, this project will be funded from the cash reserves of Mountain States Health Alliance, as stated by the Senior VP and CFO. This project is projected to be profitable in year two.

Compliance with the appropriate standards of healthcare/quality care. If approved, the applicant will seek accreditation from CARF, C-A-R-F, the Commission of Accreditation of Rehabilitation Facilities. If approved, they will seek credentialing and licensing from the Tennessee Department of Mental Health and Developmental Disabilities; and if approved, they will seek accreditation from the opioid treatment program by the Substance Abuse and Mental Health Services administrator.

For these reasons, Mr. Chairman, I move that we approve this application.

MR. DOOLITTLE: That is a valid motion. Do I see a second? Dr. Fleming. Would you call the role, please?

MR. AUSBROOKS: Jordan?

MS. JORDAN: Yes.

MR. AUSBROOKS: Gaither?

MR. GAITHER: Yes.

MR. AUSBROOKS: Mills?

MR. MILLS: Yes.

MR. AUSBROOKS: Taylor?

MR. TAYLOR: Yes.

MR. AUSBROOKS: Korth?

MR. KORTH: Yes.

MR. AUSBROOKS: Fleming?

DR. FLEMING: Yes.

MR. AUSBROOKS: Grandy?

MR. GRANDY: Yes.

MR. AUSBROOKS: Doolittle?

MR. DOOLITTLE: Yes.

MR. AUSBROOKS: Eight "yes."

MR. DOOLITTLE: The motion passes. The CON is granted. Thank you-all.

(End of excerpt.)

REPORTER'S CERTIFICATE

STATE OF TENNESSEE)
)
COUNTY OF WILSON)

I, APRIL DANIEL, Licensed Court Reporter in and for the State of Tennessee,

DO HEREBY CERTIFY the foregoing transcript of proceedings was taken at the time and place set forth in the caption thereof; the witness therein was duly sworn on oath to testify the truth; the proceedings were stenographically reported by me in shorthand; and the foregoing transcript of proceedings constitutes a true and correct transcript of said proceedings to the best of my ability.

I FURTHER CERTIFY I am not a relative or employee or attorney or counsel of any of the parties hereto, nor a relative or employee of such attorney or counsel, nor do I have any interest, financial or otherwise, in the outcome or events of this action.

IN WITNESS WHEREOF, I have hereunto affixed my signature this 31st day of August, 2016, at Lebanon, Wilson County, Tennessee.

_____
April Daniel
License No. 141
Expires: June 30, 2018